# ASSETS DECLARATION

PATIENT AND SPOUSE
Michigan Department of Human Services

| FOR OFFICE USE ONLY | | | | |
|---|---|---|---|---|
| Grantee Name | | | | |
| Grantee Client ID | | | | |
| Case Number | | | | |
| County | District | Section | Unit | Specialist |

**PLEASE PRINT**

| Patient's Name *(First, Middle, Last)* | | Phone No. of Nursing Home | Spouse's Name *(First, Middle, Last)* | | Spouse's Phone Number |
|---|---|---|---|---|---|
| Address of Nursing Home *(Number, Street, Rural Route)* | | | Spouse's Address *(Number, Street, Rural Route)* | | |
| City | State | Zip Code | City | State | Zip Code |
| Patient's Birthdate *(Mo/Day/Yr)* | Patient's Social Security Number | | Spouse's Birthdate *(Mo/Day/Yr)* | Spouse's Social Security No. (Optional) | |

This form asks questions about the property or assets owned by you and/or your spouse. This information is needed to determine your eligibility for Medicaid and the amount of assets that can be protected for the benefit of your spouse. Answer the following questions by providing information about all assets owned by you and/or your spouse as of _____. Include assets you or your spouse own jointly with family or other persons.

## ASSETS

1. Does anyone in your household have any assets (include assets held jointly)?

☐ Yes ▶ *Check all types of assets your household has and complete the table* ☐ No

- ☐ Checking/draft accounts
- ☐ Certificates of Deposit (CD)
- ☐ Cash on hand or in safe deposit
- ☐ Trust or annuities
- ☐ Life estate
- ☐ Life insurance
- ☐ Burial trust/funeral contract(s)
- ☐ Money market accounts
- ☐ Christmas club accounts
- ☐ Savings, bonds, stocks or mutual funds
- ☐ Land contract, mortgage or other notes payable to household member
- ☐ Burial plot(s), casket, etc.
- ☐ Other Assets _____
- ☐ Savings/share accounts
- ☐ Patient trust fund
- ☐ IRS, KEOGH, 401K or Deferred Compensation account(s)
- ☐ Real estate (not including place you live)
- ☐ Tools and equipment livestock or crops

| Owner(s) of asset(s) | Type(s) of asset(s) | Balance, amount or value | Name and address (bank, insurance company, etc.) | Account/policy number, etc. |
|---|---|---|---|---|
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AUTHORITY: 42 CFR Part 435.
COMPLETION: Voluntary.
PENALTY: No Medicaid.

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

## ASSETS

2. Does anyone in your household have any vehicles?

☐ Yes ▸ *Check all types of assets your household has and complete the table* ☐ No

☐ Car ☐ Truck ☐ Boat ☐ Campers / trailers ☐ Motorcycles ☐ RV ☐ Other Vehicles

| Owner(s) (As shown on vehicle title or registration) | Year | Make / Model | Amount owed |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| 3. Has anyone in your household: | |
|---|---|
| • sold or given away property, land, vehicles, stock, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within 60 months? | ☐ Yes ▸ Who:<br>☐ No |
| • filed a pending lawsuit which may bring money, property, etc.? | ☐ Yes ▸ Who:<br>☐ No |
| • received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 60 months? | ☐ Yes ▸ Who:<br>☐ No |
| • or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device? | ☐ Yes ▸ Who:<br>☐ No |

## AFFIDAVIT

I swear or affirm that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance than I am entitled to, I can be prosecuted for fraud.

| Signature (Patient or Representative) | | Date (Month, Day, Year) |
|---|---|---|
| | | |
| Two Witnesses Only<br>If Signed by Mark **X** | Signature of First Witness | Signature of Second Witness |
| | | |

**NOTE:** If you signed this application on behalf of someone else, complete the information below.

| Name (First, Middle, Last) | Phone Number | Relationship to patient | |
|---|---|---|---|
| | | | |
| Street Address | City | State | Zip Code |
| | | | |